DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HDFP
Facility ID: 00108

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245434**

2. STATE VENDOR OR MEDICAID NO. (L2) **568340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY HOME**
(L4) **1020 LARK STREET**
(L5) **ALEXANDRIA, MN** (L6) **56308**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/23/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **83** (L18)

13.Total Certified Beds **83** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Miriam Thornqust, HFE NEII 06/10/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 07/03/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **05/21/2014** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5434

On March 28, 2014 a standard survey was completed at this facility. Deficiencies were found, where corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5434

July 3, 2014

Mr. Patrick McDonald, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

Dear Mr. McDonald:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 16, 2014 the above facility is certified for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

June 10, 2014

Mr. Patrick McDonald, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

RE: Project Number S5434023

Dear Mr. McDonald:

On April 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 28, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 23, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 28, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 29, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 28, 2014, effective April 16, 2014 and therefore remedies outlined in our letter to you dated April 14, 2014, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245434	A. Building B. Wing	5/23/2014

Name of Facility	Street Address, City, State, Zip Code
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 04/16/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	MM/GA	06/10/2014	31593	05/23/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/28/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

AH Form Approved
6/10/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00108	A. Building B. Wing	5/23/2014

Name of Facility	Street Address, City, State, Zip Code
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix 21375 Reg. # MN Rule 4658.0800 Subp. 1 LSC	Correction Completed 04/16/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GA	06/10/2014	31593	05/23/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 3/28/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Protecting, Maintaining and Improving the Health of Minnesotans

June 10, 2014

Mr. Patrick McDonald, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

Re: Enclosed Reinspection Results - Project Number S5434023

Dear Mr. McDonald:

On May 23, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 28, 2014, with orders received by you on April 17, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: HDFP
Facility ID: 00108

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245434**

2. STATE VENDOR OR MEDICAID NO. (L2) **568340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY HOME**
(L4) **1020 LARK STREET**
(L5) **ALEXANDRIA, MN** (L6) **56308**

4. TYPE OF ACTION: **2** (L8)

1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/28/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **83** (L18)

13.Total Certified Beds **83** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Christina Martinson, HFE NEII 04/28/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/21/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5434

On March 28, 2014 a standard survey was completed at this facility. Deficiencies were found, where corrections are required. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2304 1332

April 14, 2014

Mr. Patrick McDonald, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

RE: Project Number S5434023

Dear Mr. McDonald:

On March 28, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Phone: (218) 332-5140
Fax: (218) 332-5196

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 7, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 7, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by June 28, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 28, 2014 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

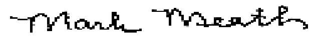
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5434s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING ______ B. WING ______	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	F441 Sorting soiled Laundry For the safety of all residents the laundry staff immediately implemented the use of protective equipment including gloves and gown when sorting soiled linens. This was completed on 3-29-14. A policy was developed on 3-31-2014 for storing soiled laundry. The purpose of this policy and procedure is to provide a process for the safe and aseptic handling and storage of linen and to prevent the spread of any potentially harmful organisms. All staff responsible for sorting soiled linens were provided education and trained on the new policy. The laundry supervisor will do audits 2 times per week for 4 weeks to assure the policy is being followed. Further audits will be completed if necessary. Results of audits will be reported to the CQI team Environmental Services Director or designee will be responsible Completion date April 29, 2014	

RECEIVED
APR 21 2014
MN Dept of Health
Fergus Falls

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patrick McDonald | TITLE: Executive Director | (X6) DATE: 4/17/14

4/28/14 OK c addendum Ba

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F 441	Continued From page 1 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure soiled laundry was handled in a manner to prevent the spread of infection through cross contamination. This practice had the potential to affect all 73 residents currently residing in the facility, who had their laundry or linens processed in the facilities laundry department. In addition, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 2 of 4 residents (R39,R70) who required blood glucose monitoring. This had the potential to affect all 7 residents who required blood glucose monitoring on the Maple Lake Unit. Findings include: During tour of laundry area on 3/27/14 at 12:22 p.m. Housekeeping/laundry coordinator (HLC) confirmed she routinely worked in the laundry department. HLC stated laundry is collected once a day in the facility and brought down to the laundry department and then sorted into separate	F 441		

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F 441	Continued From page 2 bins. HLC stated staff wear gloves to sort dirty linen and do not wear any protection to cover their uniforms while they are sorting dirty linens. HLC stated "we have never worn anything over our uniforms." The HLC confirmed there was a potential for contamination of residents and themselves. During interview on 3/27/14 at 1:25 p.m. director of nursing (DON) confirmed laundry staff do not wear gowns while sorting dirty laundry and stated that "they should be wearing a gown while sorting dirty linen." During interview on 3/28/14 at 8:51 a.m. laundry aid (LA)-A confirmed she only uses gloves to sort dirty linen and does not wear anything to protect her uniform while sorting laundry. LA-A also indicated that this was probably not good infection control practice. The facility's Linens, Handling Of policy revised 6/2011, directed staff to control infection through the handling of linens and garbage. The policy directed linen would in a bag, however, lacked direction for staff related to infection control for handling of the linen during sorting dirty linens or for handling clean linens. R39 and R70 received blood glucose monitoring on 3/24/14, without proper disinfecting of the blood glucose monitor between uses. On 3/24/14 at 5:22 p.m. licensed practical nurse	F 441		

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F 441	Continued From page 3 (LPN)-A retrieved a blood glucose monitor labeled TRUEresult on the outside of the monitor and supplies from the medication cart, and went into R39's room. LPN-A proceeded to draw a drop of blood from R39's finger and performed the blood glucose test using the blood glucose monitor. After she completed the blood glucose test, LPN-A picked up one PDI Sani-Cloth from the bottom drawer of the medication cart, and proceeded to wipe the outside surface of the blood glucose monitor for 30 seconds and allowed the monitor to dry for 10 seconds before returning the monitor to medication cart. At 5:40 p.m. LPN-A retrieved the same blood glucose monitor and supplies from the medication cart, and carried the monitor into R70's room. After completion of R70's blood glucose test, LPN-A used two PDI Sani-Cloths from the bottom drawer of the medication cart, wiped the outside of the blood glucose monitor of 30 seconds and put the monitor on the medication cart to dry for 10 seconds. During interview on 3/24/14, at 5:45 p.m. LPN-A reported the facility used the same blood glucose monitor for all of the residents on the Maple Lake unit. LPN-A stated education had been provided that directed staff to clean the multi-resident use monitors with PDI Sani-Cloths for 30 seconds, then allow to air dry for 10 seconds. During phone interview on 3/28/14, at 12:03 p.m. a representative from PDI Sani-Cloths company stated the Sani-Cloths wipes need to be in contact with the blood glucose monitor for two minutes to ensure proper disinfecting. During interview on 3/28/14, at 10:43 a.m. the director of nursing (DON) stated staff have been	F 441	Cleaning of glucometer. Policy: In accordance with infection control practices, it is the policy of Bethany that glucometer machine will be cleaned between each patient use. The procedure is to use a PDI super sani cloth to wipe the glucometer, keeping the machine wet for a 2 minute time frame and allowing it to dry prior to the next use. An educational email was sent to all staff on 4-7-2014 with the current policy and procedure for cleaning the glucometer. Implementation of individual glucometers will start on 4-15-2014. OUR NEW PROCEDURE: To assure the safety of our residents we will use individual glucometers for each resident requiring blood glucose monitoring. Single use glucometers were implemented on 4-15-14. A new Policy was implemented for cleaning of the single use meter. The manufactures recommendation for cleaning home (single resident individual meter) use glucometers is too cleaned when visibly dirty using alcohol to wipe the meter. Bethany will implement a policy to wipe the glucometer with an alcohol wipe after each use, to keep the meter clean. The glucometers will be stored in each resident's room and only used for a single resident.	

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F 441	Continued From page 4 educated to clean the blood glucose monitors with the PDI Sani-Cloths for two minutes between each use. The DON confirmed the current facility policy and stated the facility utilized one multi-resident use blood glucose monitor on each unit of the facility. Review of the PDI Super Sani-Cloth cleaning instruction sheet dated 2014, identified the cloth required a two minute contact time to ensure proper disinfection. Review of the TRUEresult Quality Assurance and Quality Control Reference Guide for Multi-Patient Use Facilities, dated 2013 identified to disinfect to destroy infectious agents on the surface of the Meter after each use, use PDI Super Sani-Cloth Germicidal Disposable wipes. the guide directed to follow the manufacturer's instructions for cleaning and disinfecting the Meter. The facility's Glucometer Cleaning policy revised 5/23/11, directed staff to use the PDI Super Sani-Cloth, and identified the wet solution must be in contact with the machine for two minutes. The policy further identified an additional application with a new wipe may be necessary to keep the machine moist for the two minutes, allow to air dry after the two minutes.	F 441	Upon discharge of the resident the glucometer will be cleaned according multi-use recommendations. This includes the use of PDI sani wipes. Manufactures recommendation for the PDI sani wipe: keeping the glucometer wet for a 2 minute time frame. The glucometer may then be assigned to a new resident. Staff were provided education on the new policy and procedure on 4-15-2014. An all house audit completed on 2-16-14 to assure all residents requiring blood glucose testing have t Results will be reported to the CQI team. heir own individual glucometer. Results will be reported to the CQI team. Clinical Director or designee will be responsible. Completion date: 4-16-14	

ECUMEN®
Bethany Community

Senior Living Services
1020 Lark Street
Alexandria, MN 56308
phone 320-762-1567
fax 320-762-5316
EcumenBethany.org

Survey date: 3-24-14 to 3-28-14

Addendum to F 441

Upon discharge of the resident the glucometer will be cleaned according to multi use recommendations.

***Audits will be completed on the next 10 discharges to assure compliance of the Policy is followed per manufactures recommendations.**

4-28-14
Deb Buker RN, DON

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5434023

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	245434	A. BUILDING 01 - NURSING HOME B. WING	03/26/2014

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Bethany Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The Bethany Home facility was surveyed as 4 buildings as follows: Building 01 - The Nursing Home, was constructed in 1962 and 1977, is 1-story, with full basement and was determined to be of Type II(000) construction. Building 02 - The Sub Acute building, was constructed in 2003, and is a 3-story structure with full basement that was determined to be of Type II (111) construction. The Sub Acute building 02 is connected to building 01 and is separated by a 2 hour fire barrier. the Sub Acute Building 02 is also connected to an assisted living occupancy that was not surveyed because the assisted living facility is separated from the the Sub Acute building 02 by a 2-hour fire barrier. Building 03 - The Chapel Addition, was constructed in 2002, is a 1-story building with no basement that was determined to be of Type IV (Heavy Timber) Building 04 - The 2012 Renovation, is the 1st	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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K 000	Continued From page 1 floor of the east wing of the Nursing Home building 01 and the South entrance of the Sub Acute Building 02 that were both fully renovated in 2012. Because building 01 is of Type II (111) construction and building 02 is of Type II (000) construction. The facility is protected throughout be an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with smoke detectors in all common areas and spaces open to the corridor installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a licensed capacity of 83 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET	K 000		

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	245434	A. BUILDING **02 - SUB ACUTE** B. WING ____________	**03/26/2014**

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **04 - 2012 RENOVATED AREA** B. WING	03/26/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET** **ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 floor of the east wing of the Nursing Home building 01 and the South entrance of the Sub Acute Building 02 that were both fully renovated in 2012. Because building 01 is of Type II (111) construction and building 02 is of Type II (000) construction The facility is protected throughout be an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with smoke detectors in all common areas and spaces open to the corridor installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a licensed capacity of 83 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET	K 000		

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2304 1332

April 14, 2014

Mr. Patrick McDonald, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5434023

Dear Mr. McDonald:

The above facility was surveyed on March 24, 2014 through March 28, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858

Phone: (218) 332-5140
Fax: (218) 332-5196

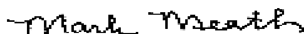
We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at the phone number above.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File 5434licltr

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00108	A. BUILDING: ______ B. WING ______	03/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/24/14 thru 3/28/14, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's signature." Make a copy of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 these orders for your records and return the original to the address below: Minnesota Department of Health Gail Anderson, Unit Supervisor 1505 Pebble Lake Road, Suite 300 Fergus Falls, MN 56537	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure soiled laundry was handled in a manner to prevent the spread of	21375		

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21375	Continued From page 2	21375		

infection through cross contamination. This practice had the potential to affect all 73 residents currently residing in the facility, who had their laundry or linens processed in the facilities laundry department. In addition, the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 2 of 4 residents (R39,R70) who required blood glucose monitoring. This had the potential to affect all 7 residents who required blood glucose monitoring on the Maple Lake Unit.

Findings include:

During tour of laundry area on 3/27/14 at 12:22 p.m. Housekeeping/laundry coordinator (HLC) confirmed she routinely worked in the laundry department. HLC stated laundry is collected once a day in the facility and brought down to the laundry department and then sorted into separate bins. HLC stated staff wear gloves to sort dirty linen and do not wear any protection to cover their uniforms while they are sorting dirty linens. HLC stated "we have never worn anything over our uniforms." The HLC confirmed there was a potential for contamination of residents and themselves.

During interview on 3/27/14 at 1:25 p.m. director of nursing (DON) confirmed laundry staff do not wear gowns while sorting dirty laundry and stated that "they should be wearing a gown while sorting dirty linen."

During interview on 3/28/14 at 8:51 a.m. laundry aid (LA)-A confirmed she only uses gloves to sort dirty linen and does not wear anything to protect her uniform while sorting laundry. LA-A also indicated that this was probably not good infection control practice.

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21375	Continued From page 3	21375		

The facility's Linens, Handling Of policy revised 6/2011, directed staff to control infection through the handling of linens and garbage. The policy directed linen would in a bag, however, lacked direction for staff related to infection control for handling of the linen during sorting dirty linens or for handling clean linens.

R39 and R70 received blood glucose monitoring on 3/24/14, without proper disinfecting of the blood glucose monitor between uses.

On 3/24/14 at 5:22 p.m. licensed practical nurse (LPN)-A retrieved a blood glucose monitor labeled TRUEresult on the outside of the monitor and supplies from the medication cart, and went into R39's room. LPN-A proceeded to draw a drop of blood from R39's finger and performed the blood glucose test using the blood glucose monitor. After she completed the blood glucose test, LPN-A picked up one PDI Sani-Cloth from the bottom drawer of the medication cart, and proceeded to wipe the outside surface of the blood glucose monitor for 30 seconds and allowed the monitor to dry for 10 seconds before returning the monitor to medication cart. At 5:40 p.m. LPN-A retrieved the same blood glucose monitor and supplies from the medication cart, and carried the monitor into R70's room. After completion of R70's blood glucose test, LPN-A used two PDI Sani-Cloths from the bottom drawer of the medication cart, wiped the outside of the blood glucose monitor of 30 seconds and put the monitor on the medication cart to dry for 10 seconds.

During interview on 3/24/14, at 5:45 p.m. LPN-A reported the facility used the same blood glucose

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21375	Continued From page 4	21375		

monitor for all of the residents on the Maple Lake unit. LPN-A stated education had been provided that directed staff to clean the multi-resident use monitors with PDI Sani-Cloths for 30 seconds, then allow to air dry for 10 seconds.

During phone interview on 3/28/14, at 12:03 p.m. a representative from PDI Sani-Cloths company stated the Sani-Cloths wipes need to be in contact with the blood glucose monitor for two minutes to ensure proper disinfecting.

During interview on 3/28/14, at 10:43 a.m. the director of nursing (DON) stated staff have been educated to clean the blood glucose monitors with the PDI Sani-Cloths for two minutes between each use. The DON confirmed the current facility policy and stated the facility utilized one multi-resident use blood glucose monitor on each unit of the facility.

Review of the PDI Super Sani-Cloth cleaning instruction sheet dated 2014, identified the cloth required a two minute contact time to ensure proper disinfection.

Review of the TRUEresult Quality Assurance and Quality Control Reference Guide for Multi-Patient Use Facilities, dated 2013 identified to disinfect to destroy infectious agents on the surface of the Meter after each use, use PDI Super Sani-Cloth Germicidal Disposable wipes. the guide directed to follow the manufacturer's instructions for cleaning and disinfecting the Meter.

The facility's Glucometer Cleaning policy revised 5/23/11, directed staff to use the PDI Super Sani-Cloth, and identified the wet solution must be in contact with the machine for two minutes. The policy further identified an additional

Minnesota Department of Health

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21375	Continued From page 5	21375		
	application with a new wipe may be necessary to keep the machine moist for the two minutes, allow to air dry after the two minutes. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures on infection control measures for sorting laundry to prevent cross contamination and educated staff on proper techniques for sorting laundry and appropriate cleaning techniques for multiple patient use equipment to prevent cross contamination. The director of nursing or her designee could then monitor the appropriate staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty One (21) days.			